

To: Department of Labor and Industries    Claim No: \_\_\_\_\_

**Please transfer my case**                      Date (changed health care providers): \_\_\_\_\_

**From:** (Name of provider) \_\_\_\_\_

**To:** (Name of new provider) \_\_\_\_\_                      Provider ID # / NPI#: \_\_\_\_\_

Address of new provider: \_\_\_\_\_

City: \_\_\_\_\_                      State: \_\_\_\_\_                      Zip: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

Claimant's name: \_\_\_\_\_                      Today's date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_                      State: \_\_\_\_\_                      Zip: \_\_\_\_\_

Claimant's signature: \_\_\_\_\_

F245-037-000 Transfer of Care Card 09-2012                      Index: TCARE

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**Mail to:**  
**Department of Labor and Industries**  
**Claims Section**  
**PO Box 44291**  
**Olympia WA 98504-4291**